Statement Of Eligibility To Serve On Roster Of Impartial Physicians

PLEASE COMPLETE BOTH SIDES, SIGN FORM, and,
RETURN FORM WITH A COPY OF YOUR ***"CURRICULUM VITAE"***

1. I have a full state license rendered by the appropriate board of registration, and an active clinical practice e.g. treatment of patients a minimum of 8 hours per week, or a combination of 4 hours of patient treatment plus 4 hours of clinical teaching or research per week; ____yes; ____no.

2. My primary board specialty: _____; date certified_____; date recertified:_____;
(secondary board specialty) _____; date certified_____; date recertified:_____;

3. My areas of practice/interest:_____;

4. I speak the following languages in addition to English:_____; _____;

5. I have a staff appointment and/or admitting privileges at the following JCAHO accredited hospital or health care organization(s) _____ (optional)

6. I have no outstanding, unresolved, non-frivolous complaints filed with the Massachusetts Board of Registration in Medicine, the National Physicians' Data Base and/or Health Care Services Board.
__yes; __no. (if "no", please explain on separate sheet.)

7. I recognize that I must disclose potential conflicts of interest from my affiliation with any independent medical examination organization or corporation of physicians which primarily provides litigation-related examinations without treatment and follow-up evaluations:

   A. ____ I am not affiliated with such organization(s).
   B. ____ I am affiliated with the following organization(s) and my work for each is as follows:

	(organization's name /address)	(this is what I do)
(1)	_____	_____
(2)	_____	_____

8. I recognize that I must disclose potential conflicts of interest from my relationship(s) with industry, insurance companies and labor groups from which I, or someone in my immediate family, receive something of value such as an equity position, royalties, consultantship, funding by research grant or payment of some service.

   A. ___ I am not aware of any such potential conflicts of interest;
   B. ___ I am aware of the following potential conflicts of interest existing during the past 12 months; (please describe potential conflicts and use additional sheet if necessary)
   _____
   _____

I understand that such potential conflicts may not disqualify me for work where the Department can assign cases so that such potential conflicts are eliminated by this disclosure statement.

PHYSICIAN'S SIGNATURE:_____ DATE:_____

PRINTED NAME: _____

9. ADDRESS FOR ALL CORRESPONDENCE email: _____

_____
_____
_____
(City/Town) (State) (Zip Code)

BILLING ADDRESS (IF DIFFERENT FROM ABOVE)

_____
_____
_____
(City/Town) (State) (Zip Code)

TELEPHONE:_____ FAX: _____

10. ADDRESS WHERE EXAMINATIONS TAKE PLACE

_____
_____
_____
(City/Town) (State) (Zip Code)

NAME OF CONTACT:_____

TELEPHONE:_____ FAX:_____

11. ALTERNATE ADDRESS WHERE EXAMINATIONS TAKE PLACE, IF APPLICABLE

_____
_____
_____
(City/Town) (State) (Zip Code)

NAME OF OFFICE CONTACT: _____

TELEPHONE: _____ FAX: _____

RETURN COMPLETED FORM AND "***CURRICULUM VITAE***"
TO:
DEPUTY DIRECTOR, DIVISION OF DISPUTE RESOLUTION,
DEPARTMENT OF INDUSTRIAL ACCIDENTS,
600 WASHINGTON ST., 7th FLOOR
BOSTON, MA 02111